UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ZAVESCA (miglustat)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- Minimum age**:** 18 years old
- Diagnosis**:** moderate type 1 Gauchers disease
- Documentation that enzyme replacement has failed.
- Documentation that hemoglobin is >9g/dL
- Platelet count >50k/ul. (**FAX COPY OF LAB WORK**)
- Written consultation with trained specialists (either a geneticist or hemotologist)

INFORMATION:

Cumulative limit**:** 90 capsules/30 days

Dosage: 100mg t.i.d. recommended. May be decreased to once or twice a day based on side effects.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy.

8/9/6